Filing at a Glance

Company:	Arkansas Blue Cross and Blue Shield
Product Name:	Supplemental Prescription Drug Benefit
State:	Arkansas
TOI:	H17G Group Health - Prescription Drug
Sub-TOI:	H17G.000 Health - Prescription Drug
Filing Type:	Form
Date Submitted:	07/19/2012
SERFF Tr Num:	ARBB-128583837
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	GMC-13, 17-280, 10-103GRPRET, 10-04RETG
Implementation Date Requested:	On Approval
Author(s):	Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s):	Stephanie Fowler (primary)
Disposition Date:	08/02/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Supplemental Prescription Drug Benefit
Project Name/Number: Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG

General Information

Project Name: Medi-Pak Retiree Coverage
Project Number: GMC-13, 17-280, 10-103GRPRET, 10-04RETG
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 08/02/2012
State Status Changed: 08/02/2012
Created By: Christi Kittler
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Arkansas is our state of domicile.
Market Type: Group
Group Market Size: Large
Overall Rate Impact:
Deemer Date:
Submitted By: Christi Kittler

Filing Description:
Attached please find group outpatient prescription drug policy forms for your review and approval, if indicated.

The purpose of this is to file a new pharmacy product, Medi-Pak® Rx Group Medicare Part D Plan Supplemental Prescription Drug Benefits.

This product provides a benefit to supplement the MediPak Rx Medicare Part D Employer Group Waiver Plan (EGWP) coverage. While Medicare Part D products are not required to be filed with states due to federal jurisdiction, this product requires filing because its supplemental benefit is provided as a separate (but integrated) product from the EGWPprimary coverage.

The Arkansas Blue Cross Supplemental Prescription Drug product will provide supplemental coverage to Medicare Part D and is not a standard Medicare Supplement product. The underlying EGWP coverage will vary, but will never include brand or specialty (as defined in the Medicare Part D program) coverage in the Part D Defined Standard coverage gap. The Arkansas Blue Cross Supplemental Prescription Drug product benefit design may also vary but will include brand and specialty drug coverage in the coverage gap.

Covered Persons will generally be required to share in the cost of drugs through copayments or coinsurance. The Part D plan formulary will dictate which drugs are covered and at what cost sharing level.

Covered Persons can access prescription drugs through retail or mail order pharmacies. Retail prescriptions are generally provided in a 34 day supply and mail order drugs are generally provided in a 90 day supply.
Drugs that are not covered under Medicare Part D may not be covered under this supplemental product. Other limitations and exclusions under this product include drugs covered under a medical insurance plan (e.g., drugs administered in a physician's office) or through other coverages (e.g., Workers' Compensation). Some drugs may be subject to utilization management edits.

Forms GMC-13, 10-103 GRPRET and 10-04RETG have been revised to include this product. Form 17-280 is new and not intended to replace any previously approved forms.

Company and Contact

State: *Arkansas* ***Filing Company:*** *Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI: *H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*
Product Name: *Supplemental Prescription Drug Benefit*
Project Name/Number: *Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

Filing Contact Information

Christi Kittler, Compliance Supervisor
320 West Capitol, Ste 211
Little Rock, AR 72201
cmkittler@arkbluecross.com
501-378-2967 [Phone]
501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield
601 S. Gaines Street
Little Rock, AR 72201
(501) 378-2967 ext. [Phone]
CoCode: 83470
Group Code:
Group Name:
FEIN Number: 71-0226428
State of Domicile: Arkansas
Company Type:
State ID Number: N/A

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	$50/form x 4 forms
Per Company:	No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	$200.00	07/19/2012	61034203

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***		***Company Tracking #:***	*GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/02/2012	08/02/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	07/31/2012	07/31/2012
Pending Industry Response	Stephanie Fowler	07/26/2012	07/26/2012

Response Letters

Responded By	Created On	Date Submitted
Christi Kittler	07/31/2012	07/31/2012
Christi Kittler	07/30/2012	07/30/2012

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***		***Company Tracking #:***	*GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
Project Name/Number:	*Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*		

Disposition

Disposition Date: 08/02/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Master Contract	Approved-Closed	Yes
Form (revised)	Benefit Certificate	Approved-Closed	Yes
Form	Benefit Certificate	Disapproved	No
Form	Group Application	Approved-Closed	Yes
Form	Retiree Application	Approved-Closed	Yes

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Supplemental Prescription Drug Benefit
Project Name/Number: Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/31/2012
Submitted Date	07/31/2012
Respond By Date	08/31/2012

Dear Christi Kittler,

Introduction:

Thank you for your response. ACA 23-79-149 (d) states that…."Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network. Is the mail order provider in the insurance policy's network? If so, there should be one co-pay for each month's supply under the 90-day supply.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Supplemental Prescription Drug Benefit
Project Name/Number: Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/31/2012
Submitted Date	07/31/2012

Dear Stephanie Fowler,

Introduction:

Thanks for the quick response

Response 1

Comments:

I was just giving examples of $ figures and not trying to tie in real benefits. I will adhere to ACA 23-79-149 (d) when assigning copayments as all mail order pharmacies are in the network. There will be no difference between a 90 day supply at a retail store vs a mail order pharmacy.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if this answers your questions.

Thanks so much!

Sincerely,

Christi Kittler

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug
Product Name: Supplemental Prescription Drug Benefit
Project Name/Number: Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/26/2012
Submitted Date	07/26/2012
Respond By Date	08/27/2012

Dear Christi Kittler,

Introduction:

The "Filing Description" indicates that insured could be "...required to share in the cost of drugs through copayments..."; please advise how these copayments will be determined and the amounts for both the 34 day supply and the 90 day supply.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking #:	ARBB-128583837	**State Tracking #:**		**Company Tracking #:**	GMC-13, 17-280, 10-103GRPRET, 10-04RETG

State:	Arkansas	**Filing Company:**	Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI:	H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug		
Product Name:	Supplemental Prescription Drug Benefit		
Project Name/Number:	Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/30/2012
Submitted Date	07/30/2012

Dear Stephanie Fowler,

Introduction:

Hi Stephanie

Response 1

Comments:

I have re-attached the benefit certificate to include a 30-day and 90-day supply of drugs available at either a retail drug store or by mail order. There is no difference in the copayment amounts for retail or mail order. Usually, the benefit structures will be set up as a 3-4 tier copay system (e.g. $5/$30/$50) during the coverage gap for single copay and potentially ($10/$60/$100) for a 90-day supply. These amounts vary by the group's request. Basically we are ensuring that the member does not pay more than the amount listed in the schedule for each tier, regardless of where they are in the Medicare PDP coverage lines.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	17-280	CER	Benefit Certificate	Initial	48.700	17-280 8-12 refile.pdf	Date Submitted: 07/30/2012 By: Christi Kittler
Previous Version							
1	*17-280*	*CER*	*Benefit Certificate*	*Initial*	*48.700*	*17-280 8-12.pdf*	*Date Submitted: 07/30/2012 By: Christi Kittler*

No Rate/Rule Schedule items changed.

Conclusion:

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***		***Company Tracking #:***	*GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
Project Name/Number:	*Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*		

Please let me know if you have further questions or need additional explanations.

Sincerely,

Christi Kittler

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***		***Company Tracking #:***	*GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
Project Name/Number:	*Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*		

Form Schedule

Lead Form Number: GMC-13

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 08/02/2012	GMC-13	POL	Group Master Contract	Revised: Replaced Form #: GMC-13 1/10 Previous Filing #: Paper	48.700	GMC-13 R8-12.pdf
2	Approved-Closed 08/02/2012	17-280	CER	Benefit Certificate	Initial:	48.700	17-280 8-12 refile.pdf
3	Approved-Closed 08/02/2012	10-103GRPRET	AEF	Group Application	Revised: Replaced Form #: 10-103GRPRET 1/10 Previous Filing #: Paper	48.700	10-103GRPRET R8-12.pdf
4	Approved-Closed 08/02/2012	10-04RETG	AEF	Retiree Application	Revised: Replaced Form #: 10-04RETG 1/10 Previous Filing #: Paper	48.700	10-04RETG R8-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***		***Company Tracking #:***	*GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
Project Name/Number:	*Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*		

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 Gaines Street
P.O. Box 2181
Little Rock, Arkansas 72203

RETIREE MEDIPAK®
GROUP POLICY

We agree to provide to the eligible Retirees of the Policyholder, and their covered Dependents, the benefits set forth in the Benefit Certificate(s) or Evidence(s) of Coverage, attached to and incorporated as part of this Policy in accordance with the terms, provisions and limitations of this Policy.

This Policy is issued in consideration of the Policyholder's Application, a copy of which is attached, the Policyholder's covenants and the Policyholder's payment of the premium.

This Policy becomes effective at 12:01 a.m. on the effective date shown on the Application. The Policy is renewable month to month, by payment of the monthly premium. The premium for the Policy may be adjusted upon thirty (30) days' notice. The Policy is subject to termination according to its terms.

The following pages, including the Benefit Certificate(s), the Evidence(s) of Coverage, the Application and any riders, endorsements or amendments are part of this Policy.

It is signed at our Home Office on the effective date.

P. Mark White

President and Chief Executive Officer

TABLE OF CONTENTS

ARTICLE I.	DEFINITIONS	3
ARTICLE II.	COVENANTS OF THE POLICYHOLDER	3
ARTICLE III.	CLAIMS	7
ARTICLE IV.	GENERAL PROVISIONS	7
ARTICLE V.	POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING	11

ARTICLE I. DEFINITIONS

A. Application means the Application that is executed by the Policyholder.

B. Benefit Certificate or Evidence of Coverage means a document containing a description of the benefits provided by the Policy.

C. Company means Arkansas Blue Cross and Blue Shield.

D. Covered Person means a Retiree or Dependent who is insured under this Policy.

E. Dependent means any member of the Retiree's family who meets the eligibility requirements of the Plan as set out in the Benefit Certificate or Evidence of Coverage, who is enrolled in the Plan and for whom the Company receives a premium.

F. Employer means a sole proprietorship, partnership or corporation that is the Policyholder.

G. Grace Period means the period of 30 consecutive days beginning with any premium due date after the first which shall be allowed for payment of premium.

H. Plan means the Retiree Health Benefit Plan established by the Employer.

I. Plan Administrator means the Employer.

J. Plan Year means the Plan Year stated in the Retiree Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Policy.

K. Policy or Group Policy means this policy and includes the Benefit Certificate or Evidence of Coverage issued to Retirees, amendments, the Application of the Employer and individual enrollment forms, under which the Company provides coverage to Covered Persons.

L. Policyholder means the Employer as shown in the Application.

M. Retiree means a person who previously qualified for coverage as an employee under the terms of the employee health benefit Plan established by the Employer, who is enrolled in the Plan as a Retiree and for whom the Company receives a premium.

ARTICLE II. COVENANTS OF THE POLICYHOLDER

As part of the consideration for this Policy, Policyholder understands, acknowledges and agrees:

A. Plan Administrator

The Policyholder is the Plan Administrator of the Employee Health Benefit Plan, the terms of which are set forth in this Policy. The Policyholder gives the Company authority and full discretion to audit Policyholder's records relating to this Policy and to determine all questions arising in connection with insurance benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions. The actions, determinations and interpretations of the Company acting on behalf of the Plan within the scope of this authority shall be conclusive and binding on the Policyholder and the Covered Person.

B. Retiree and Dependent Eligibility and Effective Dates of Coverage

The Policyholder shall accurately report Retiree and Dependent eligibility information to the Company. The provisions of the Plan outlining eligibility and effective dates of coverage for Retirees are set out in the Benefit Certificate. **The Policyholder shall indemnify the Company for any claims the Company erroneously pays or any damages the Company incurs as a result of the Policyholder failing to provide timely, accurate information to the Company of a change in the eligibility status of a Retirees or Dependent.**

C. Retiree and Dependent Participation

This Policy may be terminated by the Company if the number of insured employees or Retirees and Dependents fall below the minimum number of insured employees or Retirees and Dependents specified in the Application.

D. Contribution

This Policy may be terminated by the Company if the Policyholder fails to contribute the percentage of Retirees and Dependents' premium specified in the Application. If the Application does not specify a minimum contribution, the Company may terminate the Policy if the Policyholder fails to contribute fifty (50%) of the Retiree and Dependent's premium.

E. Payment of Premium

The Policyholder shall pay the Company the premiums for covered Retirees and Dependents every month, in advance. Payment of premium is due on the first day of the month or the fifteenth day of the month, depending upon the billing cycle established by the Company for the Policy. "Pay," "Paid" or "Payment," when used here in reference to premium, premium due dates or the Grace Period shall mean that the full amount of all funds due are actually received by the Company at its principal offices in Little Rock, Arkansas. Placing a check into the U.S. mail or with any courier service shall not constitute payment under this Policy unless or until the check is actually received by the Company at its principal office. Nor shall any invalid or dishonored check constitute payment.

F. COBRA

If COBRA applies to the Plan, the Policyholder, as Plan Administrator, must provide its Retirees and their Dependents notice of COBRA rights at the time their coverage commences under this Policy and must notify the Retiree or Dependent of his right to elect continuation of coverage under COBRA within fourteen (14) days of the happening of a "qualifying event" under COBRA. **The Company shall not assume the Policyholder's obligation to provide benefits under COBRA if the Policyholder fails to provide these notices at the times specified in this Policy, nor shall the Company be responsible for providing any COBRA notices to Employees or Dependents.**

G. HIPAA

The Policyholder, as Plan Administrator, is legally obligated, along with the Company, to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Arkansas Health Insurance Portability and Accountability Act of 1997 (each act referred to as "HIPAA"). The Policyholder shall cooperate with the Company to assure information concerning prior health insurance coverage of individuals, both Retirees and Dependents, is communicated to the Company when such individuals

are enrolled. The Policyholder shall assist the Company in providing Certificates of Creditable Coverage to individuals, both Retirees and Dependents, who terminate their coverage under this group Policy, in accordance with the provisions of HIPAA. Policyholder agrees to indemnify and hold the Company harmless if any action or inaction of the Policyholder results in the Company being charged with violating HIPAA.

H. HIPAA PRIVACY

Restrictions on the Use or Disclosure of Protected Health Information ("PHI") Policyholder (herein referred to as Employer) hereby agrees to the following restrictions on Employer's use of, access to or disclosure of PHI of Plan participants:

1. Employer may use or disclose PHI only for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules; and
2. If Employer discloses PHI to any agents or subcontractors, Employer shall first require the agents or subcontractors to agree to the same restrictions on use and disclosure of PHI as the Employer has agreed to herein; and
3. Employer shall not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of Employer; and
4. Employer will promptly report to the Plan (through the Firewall Department, as designated below) any use or disclosure of PHI by Employer or within Employer's organization that is inconsistent with the uses or disclosures allowed under this ARTICLE II. H; and
5. Employer shall allow Plan participants to inspect and copy any PHI related to the Plan participant that is in a designated record set in Employer's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules; and
6. Employer shall amend, or allow the Plan or Company as insurer of the Plan, to amend, any portion of a Plan participant's PHI, to the extent permitted or required under the HIPAA Privacy Rules; and
7. If Employer makes some types of disclosures of PHI for purposes other than payment or health care operations, Employer will make available such information as is required under the Rules to render an accounting to the Plan participant of such disclosures. Consistent with the Rules, Employer shall not be obligated to provide information for an accounting if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if the Plan participant authorized the disclosures; and
8. Employer shall make its internal practices, books, and records, relating to its use and disclosure of PHI of Plan participants available to the U.S. Department of Health and Human Services upon its request; and
9. Employer shall, if feasible, return or destroy all PHI of Plan participants in Employer's custody or control that Employer has received from the Plan (through the Firewall Department, as designated below) when Employer no longer needs such PHI to administer the Plan. If it is not feasible for Employer to return or destroy PHI, Employer will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible; and

10. Employer shall require that all Employees or classes of Employees included within the Firewall Department designation, as set forth below, must limit their access to and use of any PHI of Plan participants to activities required or needed for proper administration of the Plan and Plan benefits. Employer shall take appropriate steps to discipline including, where appropriate, termination of any Employee who violates the requirements of this ARTICLE II. H.

Designation of Firewall Department.

The following classes of Retirees or other workforce members under the control of Employer (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to PHI of Plan participants for the purposes set forth in this document:

All Employees or other workforce members under the control of Employer assigned to and working in the Human Resources Department or Division or the Employee Benefits Department or Division of Employer, or otherwise serving on a regular and routine basis to fulfill personnel or Employee benefits administration functions for Employer, including but not limited to all Employees whose job duties require communication and interaction with Company as insurer for the Plan, regarding any plan administration, claims or eligibility-related matters.

I. Agent for Retirees

The Policyholder is the agent for its Retirees and their Dependents in all dealings between Retirees or Dependents and the Company, including:

1. payment of premiums to the Company;
2. notifying the Company of changes in Retiree or Dependent status;
3. securing and forwarding to the Company applications for coverage of new Retirees or new Dependents; and
4. providing Retirees and Dependents all communications and notices from the Company.

J. Contract with Arkansas Blue Cross and Blue Shield

On behalf of Policyholder and its Retirees, the Policyholder acknowledges its understanding that this Policy constitutes a contract solely between the Policyholder and Arkansas Blue Cross and Blue Shield, that Arkansas Blue Cross and Blue Shield is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Arkansas Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that Arkansas Blue Cross and Blue Shield is not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than Arkansas Blue Cross and Blue Shield and that no person, entity, or organization other than Arkansas Blue Cross and Blue Shield shall be held accountable or liable to Policyholder for any of the obligations created under this Policy.

ARTICLE III. CLAIMS

A. Claim Processing and Claim Appeal Procedures.

The Company shall process claims and conduct appeals in accordance with the claim processing and appeal procedures set out in the Benefit Certificate.

B. Facility of Payment

1. The Company may, at its option, pay all or any benefits to the hospital, other institutions or the person giving medical services or supplies to the Covered Person.
2. Any payment made according to the above paragraph shall discharge the Company to the extent of any such payment. The Company shall not be bound to see to the use of the money so paid.

C. Legal Actions

The Covered Person may not initiate legal action with respect to a claim until the Covered Person has exhausted his or her rights of appeal under the Plan. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

D. Assignment

No assignment of benefits under this Policy shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to the Covered Person.

ARTICLE IV. GENERAL PROVISIONS

A. Entire Contract

The entire contract of insurance is made up of this Policy, the Benefit Certificate or Evidence of Coverage issued to Retirees and Dependents, amendments to the Policy, amendments to the Benefit Certificate or Evidence of Coverage and the Application of the Policyholder. The individual applications also become a part of this contract. Benefit Summary Cards issued to Covered Persons are for convenient summary only and do not constitute part of this contract of insurance. In the absence of fraud, all statements made by the Policyholder or by persons insured are representations and not warranties. No such statement shall be used in any contest under this Policy unless it is contained in a written instrument and a copy of such instrument is or has been furnished to such person.

B. Time Limit on Certain Defenses

Except for failure to comply with the participation and contribution requirements or nonpayment of premium, this Policy shall not be contested after it has been in force for two years. Statements a Covered Person makes about his insurability shall not be used to void insurance or deny a claim unless:

1. the statements are contained in a written document signed by the Covered Person; and
2. the loss on which claim is based occurs within two (2) years following the date of the signed written document.

C. Changes to Policy

1. The Company reserves the right to amend this Policy, in which case the amendment shall be deemed an amendment to the Policyholder's Retiree

health benefit plan. The procedure for amendment to this Policy and the Plan shall be that the Company shall give 30 days' written notice to the Policyholder, prior to the next renewal date of the Policy. The change shall go into effect on the date fixed in the notice.

2. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this policy. Any change or amendment must be in writing and signed by an officer of the Company.

D. Changes of Premium Rates

The premiums charged for insurance under this Policy may be changed with 30 days written notice:

1. on any premium due date; or
2. if the Policy's terms have been changed.

E. Grace Period

Any premium for this insurance which is not paid on or before the date it becomes due is in default. After the first premium payment, the Policyholder shall be allowed a [30] days Grace Period. During the Grace Period, there is no interest charge. Although the insurance shall remain in force during the Grace Period, the Company shall have the right to delay the processing of claims for services received by Covered Persons during the Grace Period, pending the payment of the premium due.

F. Termination of This Policy

1. The Policyholder may terminate this Policy on any premium due date by giving the Company written notice of termination in advance of the premium due date. Any premiums paid beyond the requested termination date shall be refunded.
2. The Company may terminate this Policy on any premium due date if:
   a. the number of insured employees or Retirees and Dependents falls below the minimum number of insured employees or Retirees and Dependents specified in the Application;
   b. the Employer fails to contribute the agreed upon share of the premiums specified in the Application; or
   c. the Employer performs an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.
3. The Company may terminate this Policy upon giving the Employer 90 days notice, in the event the Company discontinues issuing this Policy form in the State of Arkansas. In such event the Company shall offer the Employer the option to purchase any other group health insurance coverage currently being offered by the Company in Arkansas.
4. This Policy shall terminate as of the date on which the premium was due and payable, if the premium due is not paid within the Grace Period.
5. When the Policy terminates, the Policyholder is liable to the Company for payment of all premiums which are due but unpaid at the time of termination or for reimbursement to the Company for all claims paid for services incurred during the Grace Period, whichever is the greater amount.
6. It is the duty of the Policyholder, and not the Company, to notify all affected Covered Persons that the Policy and their coverage is terminated. The Company shall not be responsible under any circumstances to provide notices

to any Retiree or other Covered Person of the status of premium payments, coverage or the lack of coverage under this Policy or the Plan. However, if the Policyholder has not paid the premium during the Grace Period, the Company shall notify all Retirees and Dependents that the Policy has terminated for non-payment of premium.

7. If this Policy terminates for any of the reasons set out in ARTICLE IV, Subsection F.2 or F.4, the Policyholder shall not be eligible to reapply for another Policy with the Company for a period of six months from the date this Policy terminated.

8. If this Policy terminates due to nonpayment of premium, the Policyholder may be eligible for reinstatement in the sole discretion of the Company, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.

   a. Payment via cashier's check for all premiums due;

   b. Payment via cashier's check of a non-refundable reinstatement application fee in the amount of $350 (or such other amount as may be deemed by Arkansas Blue Cross to cover reinstatement processing); and

   c. Completion and return of a signed group application for reinstatement.

   A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the "confirmation of termination" letter. The reinstatement request will then be forwarded to a designated underwriter for review. Following review (which the Company will attempt to complete on most applications within 3-5 business days), the Policyholder will be notified of the decision regarding the reinstatement request.

G. Refunds of Premiums

If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and the Company shall have no further liability under this Group Policy.

If the Employer terminates coverage of a Covered Person, the Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

H. Claim Recoveries.

There may be circumstances in which the Company recovers amounts paid as claims expense from a provider of services, from a Covered Person or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufacturers through certain legal actions instituted by the Company relating to the claims expense of more than one Covered Person,

recoveries by the Company of overpayments made to health care providers or to Covered Persons, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Covered Person and the Company shall be entitled to retain such recoveries for its own use.

   If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Covered Person will be adjusted if affected by the recovery.

2. Only recoveries made within two years of the date of the error by the Company or overpayments to health care providers or to Covered Persons by the Company will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.

3. In the event the Company receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, the Company shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Covered Person.

4. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.

5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Covered Person and the Company shall be entitled to retain such recovery for its own use.

I. Records and Reports

The Policyholder shall keep records and furnish information to the Company upon request regarding:

1. Covered Persons and their insured Dependents;
2. changes in the amounts of insurance; and
3. termination of insurance.

J. Benefit Certificates or Evidences of Coverage

The Company shall provide the Policyholder with Benefit Certificates, Evidences of Coverage or booklets like the one which is incorporated into and made a part of this Policy. It is the obligation of the Policyholder to distribute these Benefit Certificates or Evidences of Coverage to each Covered Person.

K ERISA Notices and Plan Documents

The Policyholder, and not the Company, shall be responsible, as Plan Administrator, for providing all ERISA notices and summary plan descriptions to Covered Persons.

L. Sex and Number

When used in this Policy, the masculine includes the feminine, the singular the plural, and the plural the singular.

M. Conformity with Statutes

If any provision does not comply with any law of the State of Arkansas, this Policy is deemed amended to meet the minimum requirements of the law, unless such law is pre-empted by federal law or found to be void by a court of competent jurisdiction, in which case any amendment to the Policy required by the pre-empted or voided law shall be deemed rescinded.

ARTICLE V. POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING

A. Membership

By virtue of ownership of this Policy, the Policyholder is a member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings or assets of the Company.

B. Annual Meeting

An annual meeting of the members shall be held each and every calendar year in the State of Arkansas for the purpose of electing directors, receiving and considering reports as to the business and affairs of the Corporation and transacting such other business as may properly come before the meeting. The meeting shall be held between January 1 and April 1 of each year at such place, date and time as shall be fixed by the Board of Directors or the Chief Executive Officer. The Board of Directors may, from time to time, provide that the place, date and time of the annual meeting shall be set forth in the Policy of members as set out in ARTICLE V, Section D. below:

> "THE ANNUAL MEETING OF THE MEMBERS SHALL BE HELD EACH YEAR AT THE HOME OFFICE, LOCATED AT 601 GAINES STREET, LITTLE ROCK, ARKANSAS, ON THE THIRD MONDAY IN MARCH AT 1:00 P.M. (PROVIDED, IF SUCH DAY SHALL BE A LEGAL HOLIDAY, THEN AT THE SAME TIME AND PLACE ON THE NEXT SUCCEEDING DATE WHICH IS NOT A LEGAL HOLIDAY)."

C. Special Meetings

A special meeting of members for any purpose may be called by the Board of Directors or Chief Executive Officer, and shall be called by the Chief Executive Officer of the Secretary at the request of members holding one-third (1/3) of the voting power entitled to vote thereat. Such request shall state the purpose or purposes of the meeting, and no other business outside the scope of the state purpose or purposes shall be transacted. Unless ordered by the Board of Directors, the time and place of each special meeting of members shall be determined by the Chief Executive Officer.

D. Notice of Meetings

So long as each insurance Policy issued by the Corporation sets forth the place, date and hour of the annual meeting of members, no notice of any annual meeting shall be required to be given to any member, regardless of the number or nature of proposals to be considered and voted upon at the annual meeting. If notice of the annual meeting is not set forth in each insurance Policy, written or printed notice of the annual

meeting and every special meeting of the members, stating the place, date, time and the purpose or purposes of such meeting shall be given to the members entitled to vote at such meeting not less than ten (10), nor more than sixty (60), days before the date of the meeting. All such notices shall be given, either personally or by the mail, by or at the direction of the Chief Executive Officer or Secretary unless ordered by the Board of Directors. Notices which shall be mailed shall be deemed to be "given" when deposited in the United States Mail addressed to the member at the member's address as it appears on the records of the Corporation, with postage prepaid first class mail, if the notice is mailed thirty (30) days or less before the date of the meeting], and any notice transmitted other than by mail shall be deemed to have been "given" when delivered to the member.

E. Quorum

Except as otherwise provided by applicable law, a majority of the members of the Corporation (present in person or by proxy) shall be necessary to constitute a quorum for the transaction of business at any annual or special meeting of the members of the Corporation.

F. Voting Rights

Each member shall be entitled to one vote for each Policy held by him upon each matter coming to a vote at meetings of members provided, a group Policyholder shall be entitled to a number of votes equal to the number of certificate holders insured under this group Policy. Such vote may be exercised in person or by written proxy.

G. Vote Required

A majority of the voting power represented at any meeting of members shall be necessary and sufficient to approve any given matter. There shall be no cumulative voting.

H. Proxy

At all meetings of members a member may vote by proxy executed in writing by the member or by the member's duly authorized attorney in fact. Such proxy shall be filed with the Secretary before commencement of the meeting or at such late time as shall be expressly permitted by the Corporate officer presiding at such meeting. Each Application for an insurance Policy issued by the Corporation shall contain a provision pursuant to which the Policyholder thereof grants a revocable proxy to the Board of Directors with respect to all matters to be considered and voted upon by members at any meeting occurring while such insurance Policy is in force.

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

MEDI-PAK® Rx GROUP MEDICARE PART D PLAN
SUPPLEMENTAL PRESCRIPTION DRUG
BENEFIT CERTIFICATE

This is not a Medicare Plan

THIS CERTIFICATE PROVIDES LIMITED PRESCRIPTION DRUG BENEFITS
READ IT CAREFULLY

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201

17-280 8/12

TABLE OF CONTENTS

PURPOSE OF THIS PRESCRIPTION DRUG BENEFIT GROUP POLICY 3
SCHEDULE OF BENEFITS 3
GENERAL DEFINITIONS 4
INDIVIDUAL EFFECTIVE DATES 5
INDIVIDUAL TERMINATION DATES 5
PRESCRIPTION DRUG EXPENSE BENEFITS 5
EXCLUSIONS 6
CLAIM PROVISIONS 6
APPEALS 7
GENERAL PROVISIONS 9
ARKANSAS CONSUMERS INFORMATION NOTICE 10
LIMITATIONS AND EXCLUSION UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT 11

PURPOSE OF THIS PRESCRIPTION DRUG BENEFIT GROUP POLICY

This Policy provides supplemental coverage to the Medi-Pak® Rx Group Medicare Part D Plan purchased by the Employer for its Retirees and eligible Dependents. Under the Medicare Part D Plan Covered Persons are generally required to share in the cost of drugs through Copayments or Coinsurance. Such Copayments or Coinsurance will vary, depending upon type of drug. However, during the Medicare Part D Plan Coverage Gap stage, the Medicare Part D Plan pays reduced benefits. This policy is designed to provide supplement Medicare Part D Plan benefits so that the Covered Person's obligation during the Coverage Gap and Catastrophic stages of the Medicare Part D Plan will not exceed the normal copayment or coinsurance for a purchased drug.

SCHEDULE OF BENEFITS

1. ELIGIBILITY: The following persons are eligible for insurance under this Policy if enrolled for the Medi-Pak® Rx Group Medicare Part D Plan and eligible based on Employer's classification or guidelines.
   a) Medicare eligible Retiree;
   b) [Medicare eligible Retiree's covered Dependent]

[2. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues and ends on DECEMBER 31ST of the [same] year.]

3. COVERAGE AND BENEFIT AMOUNTS:

Prescription Drug Expense Benefit

For Total Allowed Costs within the Coverage Gap, the amount we will pay for Total Allowed Costs incurred for Prescription Drugs reduced by the amount paid under the underlying Prescription Drug Plan, if any, and pharmaceutical manufacturer discounts, if any, and subject to:

- [the following Coinsurance of the Total Allowed Cost:

Per Formulary Generic Drug	XX%
Per Formulary Brand Name Drug	
Preferred	XX%
Non-preferred	XX%
Per Non-Formulary Drug	XX% or Discount Only
Per Formulary Specialty Drug	XX%]

- [the following Copayment of:

	34-day supply*	90-day supply*
Per Formulary Generic Drug	$XX	$XX
Per Formulary Brand Name Drug		
Preferred	$XX	$XX
Non-preferred	$XX	$XX
Per Non-Formulary Drug Copayment	$XX or Discount Only	
Per Specialty Formulary Drug	$XX	$XX

*Mail Order or Retail pharmacy]

4. COVERED PERSON EFFECTIVE DATE: [The first of the month the Covered Person is effective for the Medi-Pak® Rx Group Medicare Part D Plan.]

GENERAL DEFINITIONS

“Brand Name Drug” means a prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

“Catastrophic Coverage Stage” means the stage in the Part D Drug Benefit that occurs after the True Out-of-Pocket Threshold has been met. The Catastrophic Coverage Stage lasts to the end of the Coverage Year.

[“Coinsurance” means a specified percentage (%) that a Covered Person may be required to pay as his share of the cost for a prescription drug.]

[“Copayment” means an amount that a Covered Person may be required to pay as his share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example a Copayment may be $10 or $20 for a prescription drug. If the Total Allowed Cost less any pharmaceutical manufacturer discount for the Prescription Drug is less than the Copayment, then the Covered Person will pay the lesser of the Total Allowed Cost less any pharmaceutical discount or the Copayment for the drug.]

“Coverage Gap” means the period of time under Medicare Part D that begins when a Covered Person has incurred Medicare eligible expenses for prescription drugs equal to the Initial Coverage Limit and ends when the True Out-of-Pocket Threshold amount has been met.

“Coverage Year” means a consecutive 12-month period described on the Schedule of Benefits.

“Covered Person” means a Retiree or Dependent who is insured under this Policy

“Deductible” means the amount specified in the Medicare Part D plan that a Covered Person must pay before the Medicare Part D plan begins to pay benefits.

“Employer” means a sole proprietorship, partnership, or corporation which is the Policyholder.

[“Formulary” means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes preferred and non-preferred Formulary Drugs.]

"Generic Drug" means a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

“Initial Coverage Limit” means the maximum limit of coverage under the Initial Coverage Stage of the Medicare Part D plan. The Covered Person pays a set amount until his or her payments and the plan payments reach a certain total as determined by Medicare each year. Once this limit is reached, the Covered Person enters the Coverage Gap.

"Initial Coverage Stage" means that stage of the Medicare Part D plan after the Covered Person has paid his Deductible and before the Covered Person’s total drug expense has reached an amount determined by the Medicare Part D plan, e.g. $2,930, which includes amounts paid by the Covered Person and by the Medicare Part D plan.

[“In-Network Pharmacy” means a pharmacy that is a part of [the XYZ network of participating pharmacies].]

"Medicare" means the Federal health insurance program for people 65 years or age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

"Medicare Prescription Drug Coverage" or "Medicare Part D" means a Medicare program to help pay for outpatient prescription drugs, vaccines, biologicals, and some other supplies not covered by Original Medicare (Medicare Part A or Part B).

["Out-of-Network Pharmacy" means a pharmacy that doesn't have a contract with the Medi-Pak® Rx Group Medicare Part D Plan to coordinate or provide covered drugs to members of the plan.]

"Pharmacist" means a person trained and licensed in the art of preparing and dispensing drugs.

"Prescriber" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Retiree" means an individual who meets the eligibility requirements for a Retiree as established by the Employer.

"Total Allowed Cost" means the ingredient cost plus dispensing fee plus sales tax.

"True Out-of-Pocket" means the drug costs that can be used to calculate a Covered Person's coverage under Medicare Part D that count toward a Covered Person's Medicare drug plan True Out-of-Pocket Threshold, as determined by Medicare each year. True Out-of-Pocket costs determine when a Covered Person exits the Coverage Gap and enters into the Catastrophic Coverage Stage of Medicare Part D prescription drug plan. It includes all payments for drugs listed on Covered Person's plan's Formulary and purchased at an In-Network Pharmacy.

"True Out-of-Pocket Threshold" means the upper limit of the Coverage Gap as determined by Medicare. When the upper limit is reached, you move to the Catastrophic Coverage Stage until the start of a new Coverage Year.

INDIVIDUAL EFFECTIVE DATES

Covered Person – Individual insurance will become effective as indicated on the Schedule of Benefits.

An eligible person may [enroll or be enrolled] only within [31 days after becoming eligible or during an open enrollment period], unless otherwise indicated by the policy. [Open enrollment period means a predetermined term during which any eligible person who previously did not enroll for coverage under the policy, may enroll for coverage.]

INDIVIDUAL TERMINATION DATES

Covered Person – Coverage for a Covered Person will end on the earliest of:

a) the date the Covered Person is no longer eligible [unless contributions for coverage were made in advance, in which case coverage will terminate at the end of the period for which premiums have been paid]; or
b) any premium due date, if full payment for the Covered Person's coverage is not made within 31 days following the premium due date; or
c) the date the policy terminates.

Termination will not affect a claim for benefits for covered charges that were incurred while the person was covered under this policy.

PRESCRIPTION DRUG EXPENSE BENEFITS

Once a Covered Person enters the Coverage Gap under Medicare Part D, we will pay expenses incurred by the Covered Person for Prescription Drugs newly filled or renewed by a Pharmacist subject to the amounts shown in the Schedule of Benefits. Subject to any other exclusions or limitations in the Policy, in order to be covered, the drug must be:

a) a drug covered under Medicare Part D unless otherwise specifically covered herein;
b) listed in the Formulary as utilized by [the XYZ network]; and
c) prescribed by a Prescriber.

EXCLUSIONS

The Policy does not cover:

a) any [formulary] drug expense that is:
   1. not a Medicare Part D eligible drug expense; or
   2. beyond the limits imposed by Medicare for such expense; or
   3. excluded by name or specific description by Medicare; except as specifically provided under the Policy;

b) any portion of a covered expense to the extent paid by Medicare;

c) covered expenses incurred after coverage under the Policy terminates;

d) [expenses used to meet any Copayment or Coinsurance;]

e) [expenses in excess of the percentages payable;]

f) [any drugs prescribed or dispensed by a member of the Covered Person's immediate family or by the Policyholder;]

g) [drugs not requiring a prescription;]

h) [drugs covered under a medical insurance plan]

i) [drugs covered under a Workers' compensation plan;]

CLAIM PROVISIONS

Claims under this policy will be processed at the same time claims are processed under the Medi-Pak® Rx Group Medicare Part D Plan; however, in the rare instances where a claim is not so processed, the following provisions apply.

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins, or as soon as reasonably possible. Notice should include information that identifies the Covered Person and this Policy.

Claim Forms: When we receive notice of claim, we will send forms for filing proof of loss to the Covered Person. If these forms are not sent within 15 day, the Covered Person will meet the proof of loss requirements if we are given, within 90 days, written proof of the nature and extent of the loss.

Proof of Loss: Written proof of loss must be given to us within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In

any event, proof must be given to us within 1 year after it is due, unless the Covered Person is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Covered Person, unless an Assignment of Benefits has been requested by the Covered Person. Any other benefits due and unpaid at the Covered Person's death will be paid to the Covered Person's estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after 3 years form the time written proof of loss is required to be furnished.

APPEALS

Appeals Related to Supplemental Coverage Only: The following provisions only apply to the supplemental coverage to the Medi-Pak® Rx Group Medicare Part D Plan that are provided by this Policy. For example, a Covered Person should use these provisions in filing a claim because he did not receive a reduction in his Medicare Part D Plan obligation provided by this policy. However, if a claim is denied because the Covered Person is not eligible for benefits under the Medicare Part D Plan, e.g. the prescription drug was not covered, an appeal should be filed with the Medicare Part D Plan in accordance with the terms of the Medicare Part D plans' Evidence of Coverage.

Legal Actions: Prior to initiating legal action, you must file an appeal of your claim in accordance with this Subsection. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

Who May Request a Review: A Covered Person or the Covered Person's Authorized Representative may file an appeal to request a review of a claim denial.

Where and When (Deadline) to Submit an Appeal: If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Internal Review Request" to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after you have been notified of the denial of benefits.

Documentation:

a.) Written Appeals: You must submit your appeal in writing.

b.) Appellant's Right to Information: The Company shall provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

1. were relied upon in making the benefit determination;
2. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or
3. demonstrate compliance with the terms of the Plan.

c.) Appellant's Right to Submit Information: You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

Conduct of Review:

a.) Scope of Review. The Appeals Coordinator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.

b.) Qualifications of Appeals Coordinator. The Appeals Coordinator is an individual with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual.

Timing of Appeal Determination: The Appeals Coordinator shall render a decision on an appeal related to a claim within a reasonable period of time, but notification of the Appeals Coordinator's determination shall be provided to you not later than sixty (60) days after the Appeals Coordinator received the appeal.

Notification of Determination of Appeal to Plan: The Appeals Coordinator shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

a.) The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

b.) reference to the specific plan provision(s) on which the review determination is based;

c.) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;

d.) a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;

e.) a statement describing the voluntary external review procedures offered by the Plan; and

f.) a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.

Authorized Representative:

a.) One Authorized Representative. A Covered Person may have one representative and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.

b.) Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to "You" or "Covered Person" in this document refer to the Authorized Representative.

c.) Designation of Authorized Representative. One of the following persons may act as a Covered Person's Authorized Representative:

1. An individual designated by the Covered Person in writing in a form approved by the Company;
2. The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Company;
3. A person holding the Covered Person's durable power of attorney;
4. If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
5. If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Company is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

d.) Communication with Authorized Representative.

1. If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

2. If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

3. If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Company will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Company will provide copies of such correspondence to the Authorized Representative upon request.

e.) Term of the Authorized Representative: The authority of an Authorized Representative shall continue until

1. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or

2. the Covered Person is legally competent to represent himself or herself and notifies the Company that the Authorized Representative is no longer required.

GENERAL PROVISIONS

Conformity With State Law: If any part of the policy conflicts with the law of the state of delivery on the date the policy goes into effect, the policy is amended to meet the minimum requirements of such law.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
LITTLE ROCK, ARKANSAS 72201

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2010 or toll free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.

LIMITATIONS AND EXCLUSION UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION

APPLICATION by:
(hereinafter called "Policyholder")
for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

SECTION 1. GROUP INFORMATION

Legal Name of Business:	
D/B/A:	
Street Address:	
City, State, Zip:	County:
Mailing Address: (if different from Street)	
City, State, Zip:	
Telephone #:	Fax #:
Fed. Tax I.D. #:	Business Type: [Sole Proprietorship] [Legal Partnership] [Corporation] [Government Entity]
Exec. Contact:	E-Mail:
Group Administrator:	E-Mail:
Primary SIC Code:	SIC Description:
Agent:	Agent's Lic #:
Agent's Company:	Agent's Tax Id:

SECTION 2. POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

SECTION 3. PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.

SECTION 4. BENEFIT SELECTION

☐ RETIREE MEDI-PAK® GROUP BENEFITS

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS:_____

Class	Class Description	Waiting Period	Contribution
			Retiree % Dependent %

Note: *The Employer must pay a minimum of 50% of the premium. This Policy may be terminated by the Company if the Policyholder fails to contribute the percentage of' premium specified above.*

Medicare Extended Hospital Services

100% of Medicare Part A Inpatient Hospital Deductible
Part A Medicare Eligible Expenses for 61st through 90th day per Benefit Period
Part A Medicare Eligible Expenses for 91st through 150th day (Lifetime Reserve)
Part A Medicare Eligible Expenses for additional 365 days
Part A – Blood – Cost of first 3 pints of blood
Extended Care Services received at Participating Skilled Nursing Facility during 21st through the 100th day per Benefit Period

Medicare Part B Services

100% of Medicare Part B Deductible
Part B Coinsurance for Medicare Eligible Expenses
Part B – Blood – Cost of first 3 pints of blood
Part B Medicare Excess Charges

Medically Necessary Emergency Care in a Foreign Country / Fitness Program Rider

☐ RETIREE MEDI-PAK® RX GROUP BENEFITS

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS:_____

Class	Class Description	Waiting Period	Contribution
			Retiree % Dependent %

Note: *The Employer must pay a minimum of 50% of the premium. This Policy may be terminated by the Company if the Policyholder fails to contribute the percentage of' premium specified above.*

	Option 1	Option 2
Plan Type(s)	**☐ Group PDP ☐ Group PDP Plus Supplemental Prescription Drug Benefits**	**☐ Group PDP ☐ Group PDP Plus Supplemental Prescription Drug Benefits**
Deductible		
Annual Deductible	[$325]	[$0]
Initial Coverage Period		
Generic Medications (34-day supply)	[25%]	[$5]
Preferred Brand Name Medications (34-day supply)	[25%]	[$30]
Non-Preferred Brand Name Medications (34-day supply)	[25%]	[$85]
Specialty Medications (34-day supply)	[25%]	[$85]
Other Medications	[25%]	[$85]
Gap Coverage		
Generic Medications (34-day supply)	[86%]	[$5]
Preferred Brand Name Medications (34-day supply)	[50%]	[$30]
Non-Preferred Brand Name Medications (34-day supply)	[50%]	[$85]
Specialty Medications (34-day supply)	[86%-Generic] [50%- Brands]	[$85]
Other Medications	[25%]	[$85]
Catastrophic Coverage		
Generic Medications (34-day supply)	[greater of $2.60 copay or 5% coinsurance]	[greater of $2.60 copay or 5% coinsurance]
Brand Name Medications (34-day supply)	[greater of $6.50 copay or 5% coinsurance]	[greater of $6.50 copay or 5% coinsurance]
Formulary	[Standard]	[Enhanced]

[90-Day Supply]	2.5 x 34-day copay	1.5 x 34-day copay

[**Rates**

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.]

SECTION 5. ATTESTATIONS

There are a number of federal regulations that impact small group business owners, either in requirements to provide health plan benefits or the types of benefits that must be offered. Our goal is to assist you in meeting these requirements, to help us accomplish this we ask that each small group business owner provide us with answers to the questions below.

COBRA – Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.[1]

Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees. (Yes__) (No__)

If yes, do you wish to use the services of Ceridian? (Yes__) (No__)

If no, who will administer Cobra for you? _____

Medicare Secondary Payer – If you have employees who are over 65 and enrolled in Medicare, Medicare will pay as "primary" if you have less than 20 employees (note that other criteria may apply as well). If Medicare is primary, we will offer lower "group health plan" rates to your employees who are over 65 and have their Medicare card, but not if Medicare is secondary. The count of employees is determined on whether or not you employed 20 or more full time and part time employees each working day of 20 or more calendar weeks during the current or the previous calendar year.

Under the governmental guidelines discussed above, the group health plan will result in Medicare being the secondary payer, due to meeting the criteria for 20 or more employees as defined above. (Yes__) (No__)[2]

Medicare Prescription Drug Group Plans – There are a number of federal regulations that impact Medicare Prescription Drug group plans. Policyholder agrees to comply with all applicable Medicare Prescription regulations, specifically including Chapter 3, Enrollment, Eligibility and Disenrollment of the Medicare Prescription Drug Internet Only Manual.

Policyholder agrees to reduce up-front the premium contribution required for those retirees or dependents that are eligible for Low-Income Subsidy. If Group plan is not able to reduce up-front the premiums paid by the retiree/dependent, the group plan agrees to directly refund the amount of the low-income premium subsidy up to the monthly premium contribution previously collected from the retiree/dependent. The refund must be completed within 45 days of CMS payment to Arkansas Blue Cross.

[1] COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).

[2] 42 CFR §411.170.

SECTION 6. RETIREE / DEPENDENT INFORMATION, MINIMUM NUMBER OF INSURED RETIREES / DEPENDENTS & MINIMUM PARTICIPATION REQUIREMENTS.

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

	In State	OUT OF STATE	TOTAL
Total Number of Retirees and Dependents			

Minimum Number of Insured Retirees and Dependents. To meet group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. A group must maintain 25 enrolled Retirees and Dependents to remain active in the plan.

This Policy may be terminated by the Company if the number of insured Retirees and Dependents fall below the minimum number of insured Retirees and Dependents specified above.

SECTION 7. SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate(s) or Evidence(s) of Coverage.

I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____day of _____ 20____
(City, State)

_____ [full legal name of Policyholder]

By: _____ _____

Authorized Signature | Printed Name

_____

Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the individual applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its retirees including the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

_____ _____

Agent Signature | Insurance License #/Agency Fed. Tax ID#

_____ _____

Agent Printed Name | Date

Arkansas BlueCross BlueShield
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RETIREE APPLICATION

Please check the appropriate box and fill in blanks below in ink.

Group No.: **I.D. No.:**

[☐Retiree Medi-Pak® Group]
[☐Retiree Medi-Pak® Rx Group (PDP)]
[☐Retiree Medi-Pak® Group & Medi-Pak® Rx Group (PDP)]
[☐Retiree Medi-Pak® Rx Group (PDP) Plus Supplemental Prescription Drug Benefits]
[☐Retiree Medi-Pak® Group & Medi-Pak® Rx Group (PDP) Plus Supplemental Prescription Drug Benefits]

FOR OFFICE USE ONLY

☐ Retiree Retirement Date: _____ ☐ Spouse ☐ Disabled Dependent

☐ COBRA Effective Date (Mo. / Day / Year) ☐ COBRA Termination Date (Mo. / Day / Year) Reason for COBRA:

SECTION 1. APPLICANT INFORMATION

First Name:	Middle Name:	Last Name:

Residential Address:	City:	State:	Zip Code:
Mailing Address:	City:	State:	Zip Code:

Home Phone No.	Alternate Phone No.

Social Security Number	Birth Date (mm/dd/yyyy)	Gender (F/M)

Medicare Health Identification Contract (HIC) Number	Medicare Part A Effective Date	Medicare Part B Effective Date

SECTION 3. OTHER MEDICAL INSURANCE

Will you, your spouse or your disabled dependent be continuing any other health insurance coverage, including Medicare?
You ☐ Yes ☐ No Spouse ☐ Yes ☐ No Disabled Dependent ☐ Yes ☐ No

Name of Insurance:

Member ID #:

Group Number:

Does this insurance include prescription drug coverage? ☐ Yes ☐ No

SECTION 4. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

Important Information if you are enrolling in Medi-Pak® Rx Group (PDP)

Medi-Pak® Rx Group (PDP) is a Medicare drug plan and has a contract with the Federal government. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Medi-Pak® Rx Group will end that enrollment. I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Release of information

By joining this Medicare prescription drug plan, I acknowledge that Medi-Pak® Rx Group will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medi-Pak® Rx Group will release my information, including prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

By completing this enrollment application, I agree to the following:

I understand that the benefits for which I (we) will be eligible are those described in the Group Policy and Benefit Certificate(s) or Evidence(s) of Coverage and may from time to time be changed. I understand that coverage will not become effective before the approved effective date. I understand that this coverage is in addition to my coverage under Medicare; therefore, I must keep my Medicare Part A and Part B coverage. I understand that it is my responsibility to inform Arkansas Blue Cross of any medical or prescription drug coverage that I have or may get in the future.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Arkansas Blue Cross or Medicare.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant	Signature of Applicant	Date
Print Employer/Group Administrator*	Signature Employer/Group Administrator*	Date

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone Number:

Relationship to Enrollee:

Note: An applicant's authorized representative must supply a copy of the applicant's durable power of attorney appointing the authorized representative the applicant's attorney in fact.

SERFF Tracking #:	*ARBB-128583837*	***State Tracking #:***	***Company Tracking #:*** *GMC-13, 17-280, 10-103GRPRET, 10-04RETG*

State:	*Arkansas*	***Filing Company:***	*Arkansas Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H17G Group Health - Prescription Drug/H17G.000 Health - Prescription Drug*		
Product Name:	*Supplemental Prescription Drug Benefit*		
Project Name/Number:	*Medi-Pak Retiree Coverage/GMC-13, 17-280, 10-103GRPRET, 10-04RETG*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	08/02/2012
Comments:	See attached.		
Attachment(s):			
Flesch Certification Form.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	08/02/2012
Bypass Reason:	Applications are included under the Form Schedule tab.		
Comments:			

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

RE: **Arkansas Blue Cross and Blue Shield**
Form No. GMC-13 R8/12, 17-280 8/12, 10-103 GRPRET R8/12 and 10-04RETG R8/12

FLESCH READING EASE CERTIFICATION

This is to certify that he above referenced documents have achieved a Flesch Reading Ease Score average of 48.7 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Health Insurance Policy Language Simplification Act.

Name

Senior Vice President
Title

July 18, 2012
Date